History and Context

For a review of the history and purpose of these reports, the reader is referred to the "New TDO Exception Reporting Data Overview" document dated January 2015, which is available on the Department of Behavioral Health and Developmental Services (DBHDS) website at the following link: www.dbhds.virginia.gov/professionals-and-service-providers/mental-health-practices-procedures-and-law/data. Previous monthly reports can also be located on this page.

This document is the eighth monthly report of data[1] collected to date from Community Services Boards (CSBs) and regions[2] for fiscal year 2015. The following sections contain the summaries and graphs of the monthly data reported to DBHDS through February 2015. During the month of February 2015, there were an average of 1,353 emergency calls received, 217 emergency evaluations completed and 63 TDOs issued and executed each day across the Commonwealth. Total counts of events are presented for each month and for the state fiscal year (FY) to date for ease of comparison and trend analysis.[3] Additionally, certain high risk events are reported separately by CSBs, on a case-by-case basis as they occur. These involve individuals who are evaluated and need temporary detention, but do not receive that intervention. There were four such events in the February 2015 reporting period.

Each of these events triggers submission of an incident report to the DBHDS Quality Oversight Team [4] within 24 hours of the event. The reports describe the incident as well as initial actions to resolve the event and prevent such occurrences in the future. In each case, DBHDS Quality Oversight Team reviews the incident report and actions of the CSB for comprehensiveness and sufficiency, and responds accordingly if additional follow up is needed. CSBs continue to update DBHDS until the situation has resolved and follow up is completed.

Of the four events reported in February, two involved elopements, one from an emergency department and one from a crisis assessment center. Another event involved an individual in an Intensive Care Unit (ICU) with complicated medical needs, for whom the attending physician declined to delay discharge while a temporary detention facility was located. None of these three individuals were under an ECO. The last case involved an individual who was assessed in an emergency department (ED) while under an ECO. Technical issues with the facility's fax machines delayed finding an appropriate temporary detention facility. In all of these cases a TDO was subsequently executed for the individuals. Additional detail on each of these cases can be found in Appendix D, page 21.

[1] See Appendix A for complete detailed listing of these definitions.

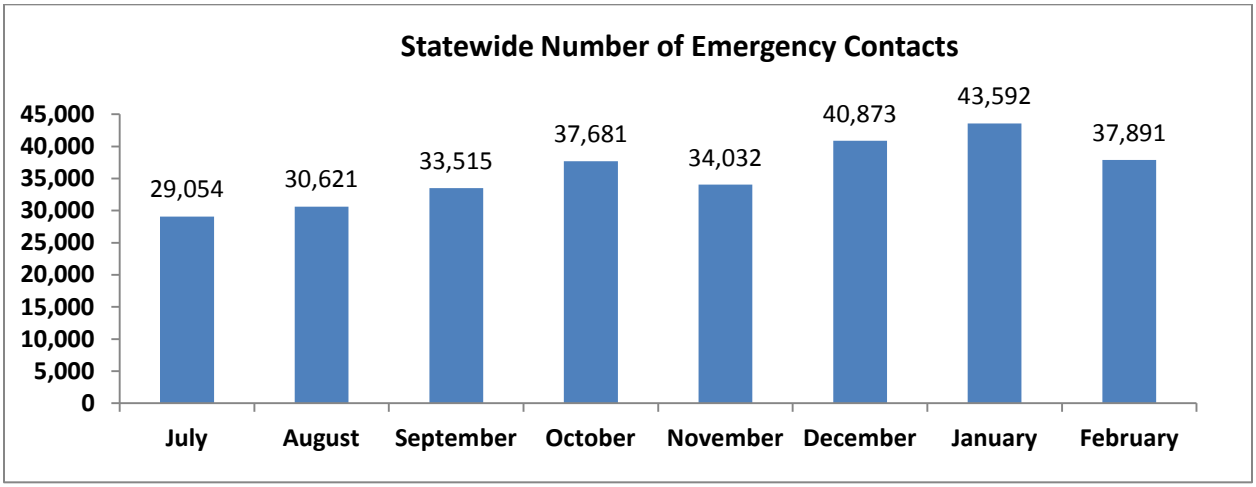
[2] There are 39 Community Services Boards and 1 Behavioral Health Authority in the Commonwealth, referred to in this report as CSBs. See Appendix B for a complete listing of CSBs within each of the seven regions.

[3] In addition, data is reported both statewide and by region in the report and in Appendix C.

[4] The Quality Oversight Team includes the DBHDS Medical Director, Assistant Commissioner for Behavioral Health, Director of Mental Health, and MH Crisis Specialist.

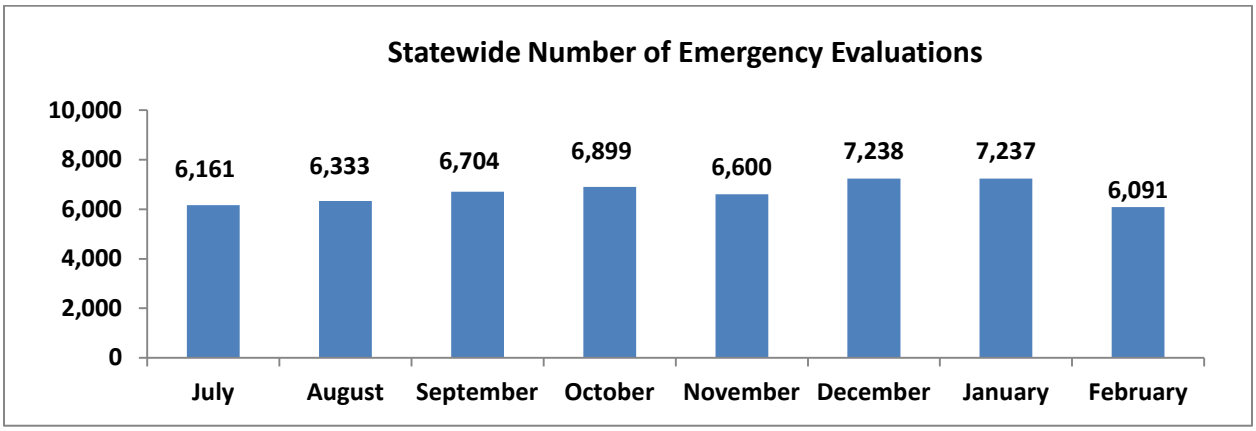
Graph 1. Emergency contacts statewide

Emergency contacts are events requiring any type of CSB emergency service involvement or intervention. There were 37,891 emergency contacts reported statewide during the month of February, 2015, which is a 13% decrease from January 2015. While this appears to end a general trend upward since July, 2014, these figures have been highly variable each month, as shown in Graph 1, below. Regional data are displayed in graph 1a and table 1 in Appendix C, page 12. All regions reported decreases in the number of contacts in February with region 5 decreasing 16% from January, after reporting a 38% increase from December to January. Region 3 reported a 22% decrease from January, continuing a decrease since December, 2014. To date, no CSBs or regions have been able to identify any specific local events, agency actions or system changes having a direct influence on the volume of crisis contacts. DBHDS initiated specific inquiries within Region 5 to better understand the causes of these fluctuations in that region, and Daniel Herr, DBHDS Assistant Commissioner for Behavioral Health, met with CSB Executive Directors in region 5 on May 4 to address this matter directly. As stated in previous reports, refinements in data gathering procedures at the local level combined with clarification of data definitions by DBHDS in November 2014 have likely also influenced the variability if these numbers.



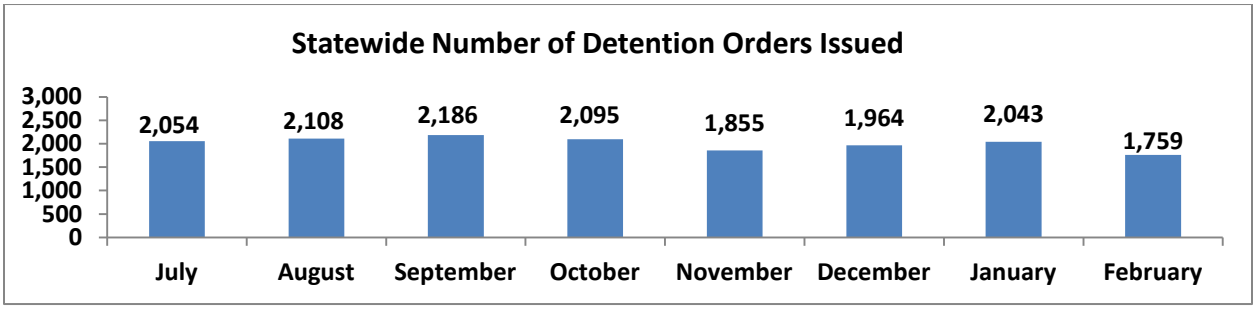
Graph 2. Emergency evaluations statewide

Emergency evaluations are comprehensive in-person clinical examinations conducted by CSB emergency services staff for individuals who are in crisis. The number of emergency evaluations reported statewide in February was 6,091, which is a 16% decrease from January. These are the lowest monthly figures for emergency evaluations in SFY 15. All regions reported decreases in evaluations, but of note, Region 7 reported a 51% decrease, Region 3 decreased by 22% and Region 5 decreased by 17% from January. Regional data is displayed in graph 2a and table 2 in Appendix C, page 13. The figures for emergency contacts, emergency evaluations, and TDOs that are reported in subsequent pages of this report may represent duplicated (i.e., not mutually exclusive) counts of individuals because an individual may have made contact, or been evaluated or detained, on more than one occasion and could therefore be included two or more times in any of these categories.



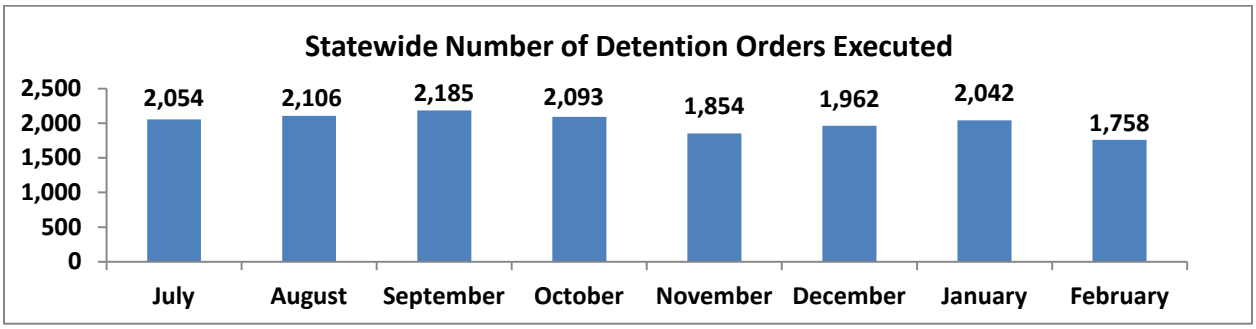
Graph 3. TDOs issued statewide

A TDO is issued by a magistrate after considering the findings of the CSB evaluation and other relevant evidence, and determining that the person meets the criteria for temporary detention under § 37.2-809 or § 16.1-340.1. A TDO is executed when the individual is taken into custody by the officer serving the order. In February, there were 1,759 TDOs issued (Graph 3), and 1,758 TDOs executed (Graph 4).These are the lowest monthly figures in SFY 2015, and all regions reported lower numbers from January. Of particular note, Region 5 decreased by 24%. Graph 3a and table 3 (page 14) and graph 4a and table 4 (page 15), display this data reported by region in Appendix C. This is a decrease of 284 TDOs issued and executed from January, 2015, representing a decrease of approximately 14% statewide. **About 71% of the emergency evaluations reported in February (4,332 of 6,091) did not result in a TDO.**



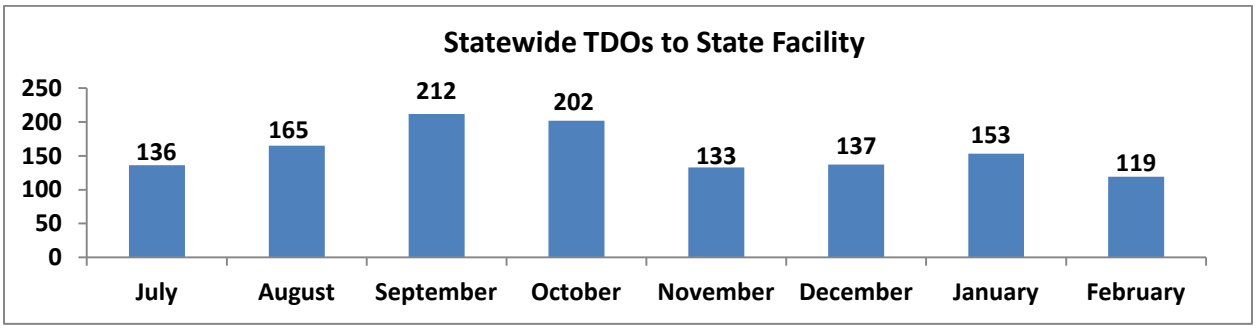
Graph 4. TDOs executed statewide

There was one temporary detention order issued but not executed during the month of February. The individual was assessed while under an ECO and determined to meet TDO criteria. After the TDO was issued the emergency room physician determined the individual's medical needs were urgent so an admission to the medical facility occurred. After receiving medical care the individual was evaluated and determined to no longer meet the criteria for TDO. The individual was discharged from the medical facility and returned to live at home with family out of state.



Graph 5. TDO admissions to a state hospital statewide

Of the 1,758 TDOs executed in February, 119 (< 7%) resulted in the individual being admitted to a state hospital [5] (Graph 5), representing a decrease of 22% from January. This is the lowest figure for this data in SFY 2015. Five regions reported decreases of over 25%. However, regions 4 and 7 reported increases. There continues to be variance among regions in the number of state hospital TDO admissions, as shown in Graph 5a and table 5 in Appendix C, page 16. This variance reflects recognized seasonal trends and each region's unique resources, protocols, and access to community psychiatric facilities. DBHDS continues to work with regions to minimize usage of state facilities for temporary detention through increased use of community psychiatric resources, alternatives to hospitalization, and more explicit utilization protocols for state hospitals. DBHDS also closely monitors use of the Psychiatric Bed Registry.

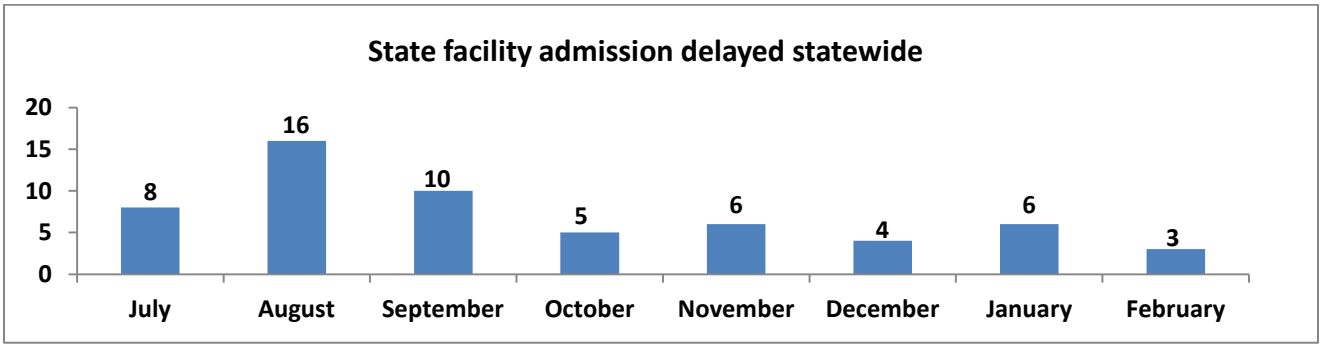


Graph 6. State hospital admission delayed statewide

In February, there were three occasions when the state hospital was deemed the "hospital of last resort" but admission could not be accomplished before the ECO time period expired (Graph 6). The delays in these cases were due to the individuals' more immediate medical testing and treatment needs. All of these individuals were ultimately admitted to the state psychiatric hospital. This is a 50% decrease in the number of delayed admissions from January (January = 6, February =3) and continues the overall

[5] Source: DBHDS AVATAR admitting CSB data

downward trend since August. Graph 6a and table 6 displays this data by region in Appendix C, page 17, and shows that regions 1, 3, 4, 6 and 7 did not experience this type of occurrence in February.



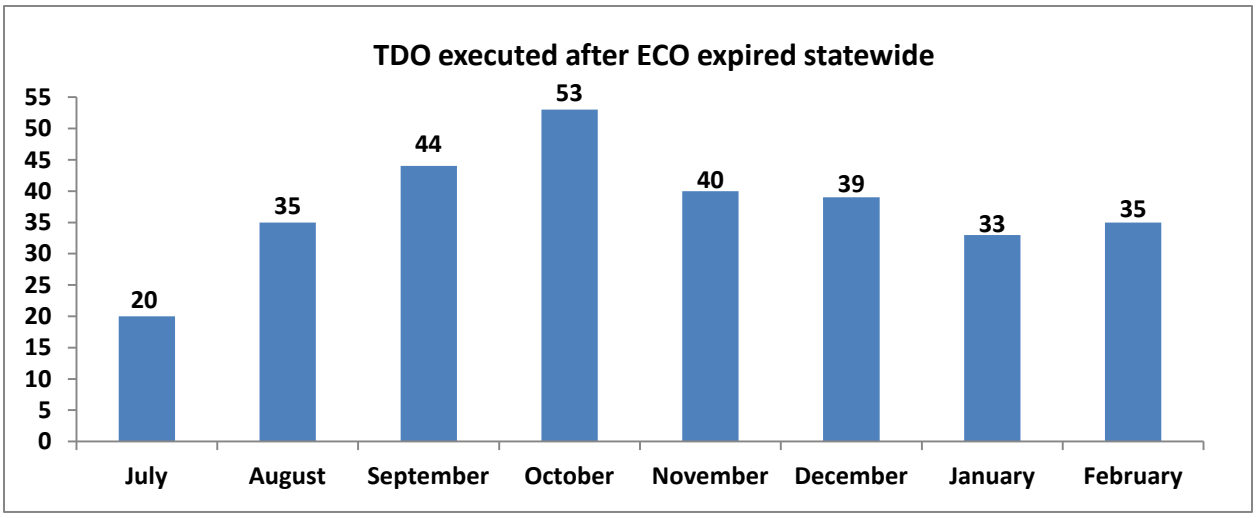
Graph 7. TDO executed after ECO expired statewide

In February, there were 35 (<2%) reported cases where a TDO was issued but not executed until after the ECO period had ended (Graph 7). This is a 6% increase from January, a slight uptick after a steady downward trend from the peak in October 2014. The majority of these cases (20 of the 35) involved waiting for law enforcement to execute TDOs that were issued prior to the expiration of the ECO time period. In seven more cases, law enforcement declined to execute the TDO until medical treatment was completed. One was the result of the CSB receiving late notification of the individual under ECO, two were the result of technical difficulties with fax machines, one was due to delayed access to a magistrate and three were as a result of CSB staff error. Each of the agencies with CSB staff error have provided staff remediation and training for all emergency evaluators to prevent this type of delay in the future. In 33 of these cases, the individuals were maintained safely in an emergency department, either locked (16) or unlocked (17), with law enforcement or security presence, and ultimately admitted to a psychiatric hospital without any lapse in custody. The remaining individuals were maintained safely within a medical unit of a hospital or a residential crisis stabilization center. These individuals were also all admitted to a psychiatric hospital without any loss of custody. Providers continue to use secure environments (such as locked emergency department or secure assessment sites) as well as law enforcement officers, to maintain custody.

Graph 7a and table 7 display this data by region in Appendix C, page 18. Regionally, frequency of these cases is highly variable. There were no events of this type in Region 4 during February, 2015.

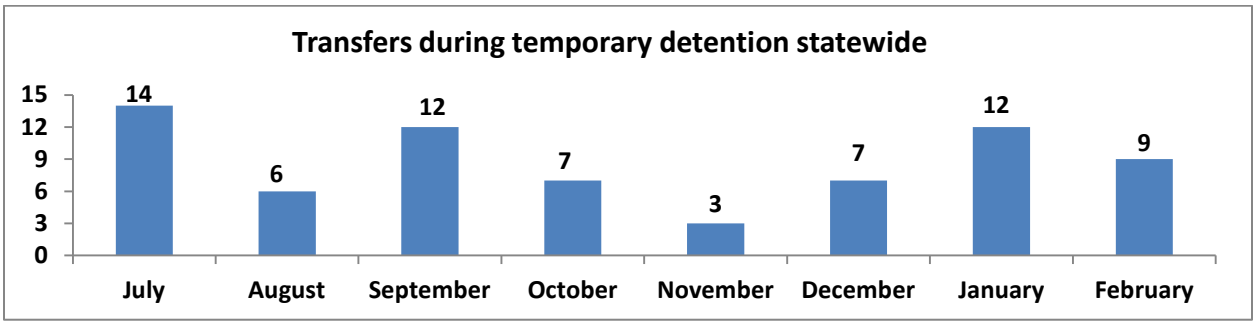
Region 7, however, continues to have a significantly greater number of these cases than any other region, and have had more of these events than all other regions combined since December. This region reported 123 TDOs issued and executed during February, 2014, with 15% reported being executed after the ECO period expired. The time delay between issuance and execution of TDOs ranges from 37 minutes to 13 hours and eight minutes with a mean of 4 hours and 52 minutes. DBHDS has continued meetings with the Executive Director and Clinical Director of Blue Ridge Behavioral Health (BRBH), the CSB serving the five metropolitan Roanoke area jurisdictions, to implement a quality improvement strategy to

identify the primary drivers of these cases and to engage key partners on ways to reduce these delays. To date, the efforts continue to target Carillion Emergency and Police Departments, the Roanoke City Sheriff and Magistrate, and Catawba Hospital. DBHDS maintains continuous monitoring of this effort. DBHDS Quality Oversight Team members attended the community partner meeting with the local CSB on May 6, 2015. A new system, that was supposed to be implemented on April 15, 2015, to take advantage of the 2015 statutory change designating the Carillion Police as a law enforcement agency, has not yet been implemented as promised. By transmitting TDOs electronically from the magistrate to the Carillion Emergency Department, the Carillion Police will be able to execute these TDOs more rapidly following issuance. DBHDS and the local agencies are continuing to monitor and address these transactions .



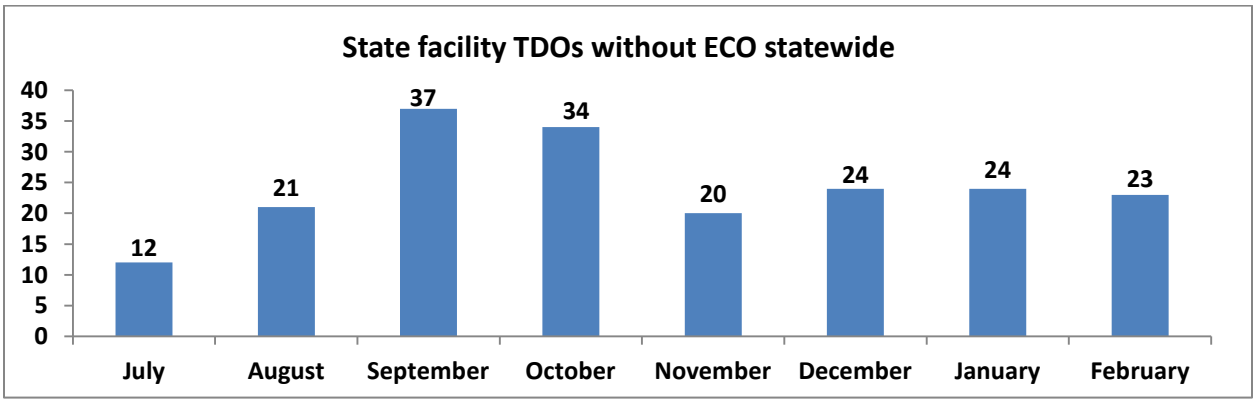
Graph 8. Transfers during temporary detention statewide

Section § 37.2-809.E. of the *Code of Virginia* allows an individual to be transferred during the period of detention from one temporary detention facility to another more appropriate facility in order to address an individual's security, medical or behavioral health needs. This procedure was used nine times (<1%) during February (Graph 8). In seven cases, the transfer was from a state facility to a private facility and two were from a private facility to a state facility. One of the transfers from a private facility to a state facility occurred due to hazardous road conditions which developed during the transport to the private facility. The road conditions warranted a change in the facility of detention to the geographically closer state facility. Graph 8a and table 8 displays this data by region in Appendix C, page 19. Regions 5, 6 and 7 did not report any of these transfers in February.



Graph 9. State hospital TDOs without ECOs statewide

As the hospital of "last resort", DBHDS facilities admit individuals who need temporary detention for whom no alternative placement can be found, whether or not the individual is under an ECO. CSBs report every "last resort" admission where no ECO preceded the admission, along with how many alternate facilities were contacted and the reason(s) for the inability to locate an alternate facility. In February, there were 23 such admissions to a state facility, a steady trend since December, 2014 (Graph 9). A total of 197 contacts were made for an average of about eight alternate facilities contacted to secure these admissions. Five of the admissions were for specialized care due to the individual's age (either minor or adult aged 65 and older) while nine of the admissions were due to lack of capacity of the alternate facilities contacted by the CSBs. Other reasons for these admissions were diagnosis of intellectual or developmental disability; medical needs beyond the capability of the alternate facilities contacted; and hazardous road conditions. DBHDS monitors the Psychiatric Bed Registry daily for updating by facilities regarding their bed space capability as well as the comments entered by CSB clinicians who use the registry in seeking a bed. Graph 9a and table 9 displays this data by region in Appendix C, page 20.



Discussion:

To enhance consistency and accuracy of CSB reporting, DBHDS has worked continuously since July with individual CSBs and regions to ensure that data elements and reporting procedures are clearly understood and consistently reported. DBHDS and CSBs have established a workgroup consisting of CSB Executive Directors and DBHDS representatives that has developed a quality review framework to further

strengthen the quality oversight processes and ensure this data is consistently used by CSBs to identify trends and correct problems at the agency, regional, and statewide levels. These data enable DBHDS to conduct ongoing system monitoring and performance improvement efforts. As a result, DBHDS, CSBs, and local emergency service partners are communicating more regularly and timely to improve local care coordination, eliminating system gaps and clarifying agency and staff roles in the emergency response system. Lastly, DBHDS continues to convene regular and frequent stakeholder meetings at the state level to share this data, communicate directly about problem issues, and jointly develop and implement effective operational improvements.

APPENDIX A

Data Elements Reported Monthly by CSB/BHAs

Each CSB/BHA reports four data factors on volume to the region:

1. Emergency contacts: The total number of calls, cases, or events per month requiring any type of CSB emergency services involvement or intervention, whether or not it is about emergency evaluation, and regardless of disposition. Calls seeking information about emergency services, potential referrals, the CSB, etc., should be counted if the calls come to emergency services (e.g., through the crisis line) and require emergency services to respond. Any other contacts to emergency services from individuals, family members, other CSB staff, health providers or any other person or entity, including contacts that require documentation in an individual's health record, should be counted as emergency contacts. Any contacts that precipitate an intervention or emergency response of any kind should be counted as emergency contacts.
2. Emergency Evaluations: Emergency evaluations are clinical examinations of individuals that are performed by emergency services or other CSB staff on an emergency basis to determine the person's condition and circumstances, and to formulate a response or intervention if needed. This figure is the total number of emergency evaluations completed, regardless of the disposition, including evaluations conducted in person or by means of two-way electronic video/audio communication as authorized in 37.2-804.1.
3. Number of TDOs Issued: TDOs are issued by a magistrate.
4. Number of TDOs Executed: TDOs are executed by law enforcement officers. A TDO is executed when the individual is taken into custody by the law enforcement officer serving the temporary detention order. It is possible under some circumstances that a TDO issued by a magistrate may not be executed for some reason.

Each CSB/BHA also reports six additional data elements:

1. Cases where the state hospital was used as a “last resort”: Under the new statutory procedures effective July 1, 2014, when an individual is in emergency custody and needs temporary detention, and no other temporary detention facility can be found by the end of the 8-hour period of emergency custody, then the state hospital shall admit the individual for temporary detention. Each region's Regional Admission Protocol describes the process to be followed for accessing temporary detention facilities and for accessing the state hospital as a "last resort" facility for temporary detention.
2. Cases where a back-up state hospital was used: Under some circumstances, the primary state hospital may not be accessible as the "last resort" temporary detention facility when needed at the end of the 8-hour ECO period, and a back-up state hospital will need to admit the individual as a "last resort" admission.
3. Cases where the state hospital is called upon as the "last resort" for temporary detention, but admission cannot occur at the 8-hour expiration of the ECO because of a medical or related clinical issue that must be addressed (i.e., medical condition cannot be treated effectively in the state hospital, person is not medically stable for transfer to state hospital, required medical testing is not yet completed, etc.).

4. Cases where a TDO may be issued by a magistrate while the person is in emergency custody, but the TDO will not be executed until after the 8-hour period of emergency custody has expired. Under the new statutes, if this scenario should occur, the individual may not be released from the CSB's custody until the TDO is executed.
5. Cases where a facility of temporary detention is transferred post-TDO: a CSB is allowed to change the facility of temporary detention for an individual at any time during the period of temporary detention pursuant to 37.2-809.E.
6. Cases where there is no ECO, but TDO to state hospital as a “last resort”: These are instances when an individual who is not in emergency custody (i.e., no ECO) is deemed to need temporary detention. If no suitable alternative facility can be found, state hospitals must serve as the "last resort" temporary detention facility in these cases.

Note: For the six data elements immediately above, associated descriptor information is reported as well.

APPENDIX B

Partnership Planning Region	Community Services Board or Regional Behavioral Health Authority
1 Northwestern Virginia	Horizon Behavioral Health Services Harrisonburg-Rockingham CSB Northwestern Community Services Rappahannock Area CSB Rappahannock-Rapidan CSB Region Ten CSB Rockbridge Area Community Services Valley CSB
2 Northern Virginia	Alexandria CSB Arlington County CSB Fairfax-Falls Church CSB Loudon County CSB Prince William County CSB
3 Southwestern Virginia	Cumberland Mountain CSB Dickenson County Behavioral Health Services Highlands Community Services Mount Rogers CSB New River Valley Community Services Planning District One Behavioral Health Services
4 Central Virginia	Chesterfield CSB Crossroads CSB District 19 CSB Goochland-Powhatan Community Services Hanover CSB Henrico Area Mental Health & Developmental Services Board Richmond Behavioral Health Authority
5 Eastern Virginia	Chesapeake CSB Colonial Behavioral Health Eastern Shore CSB Hampton-Newport News CSB Middle Peninsula-Northern Neck CSB Norfolk CSB Portsmouth Department of Behavioral Healthcare Services Virginia Beach CSB Western Tidewater CSB
6 Southern	Danville-Pittsylvania Community Services Piedmont Community Services Southside CSB
7 Catawba Region	Alleghany Highlands CSB Blue Ridge Behavioral Healthcare

APPENDIX C

Graph 1a. Emergency contacts by region

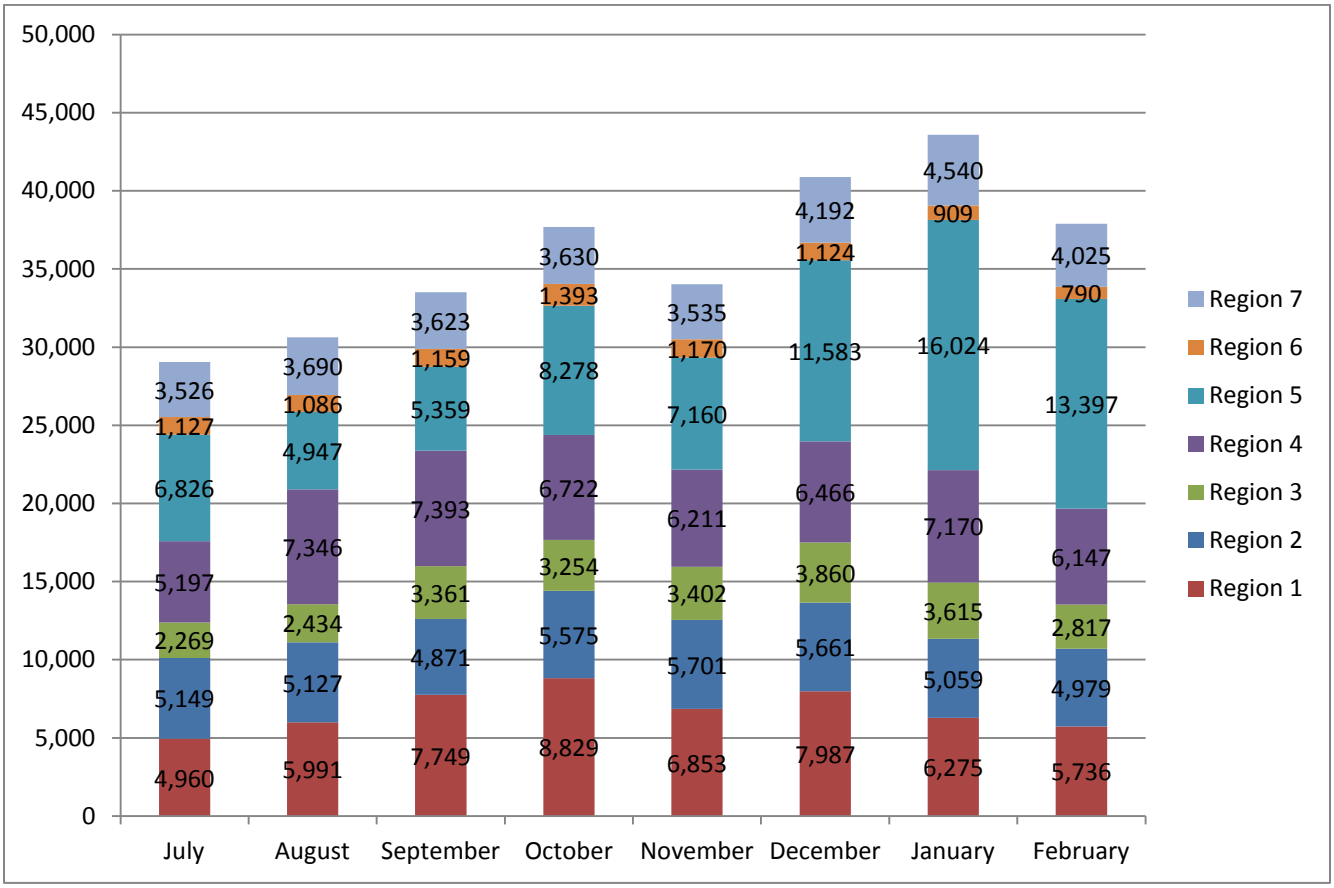


Table 1. Number of emergency contacts (corresponds with graph 1a)

Region	July	August	September	October	November	December	January	February	Total
Region 1	4,960	5,991	7,749	8,829	6,853	7,987	6,275	**5,736**	**54,380**
Region 2	5,149	5,127	4,871	5,575	5,701	5,661	5,059	**4,979**	**42,122**
Region 3	2,269	2,434	3,361	3,254	3,402	3,860	3,615	**2,817**	**25,012**
Region 4	5,197	7,346	7,393	6,722	6,211	6,466	7,170	**6,147**	**52,652**
Region 5	6,826	4,947	5,359	8,278	7,160	11,583	16,024	**13,397**	**73,574**
Region 6	1,127	1,086	1,159	1,393	1,170	1,124	909	**790**	**8,758**
Region 7	3,526	3,690	3,623	3,630	3,535	4,192	4,540	**4,025**	**30,761**
Total	**29,054**	**30,621**	**33,515**	**37,681**	**34,032**	**40,873**	**43,592**	**37,891**	**287,259**

Graph 2a. Emergency evaluations by region

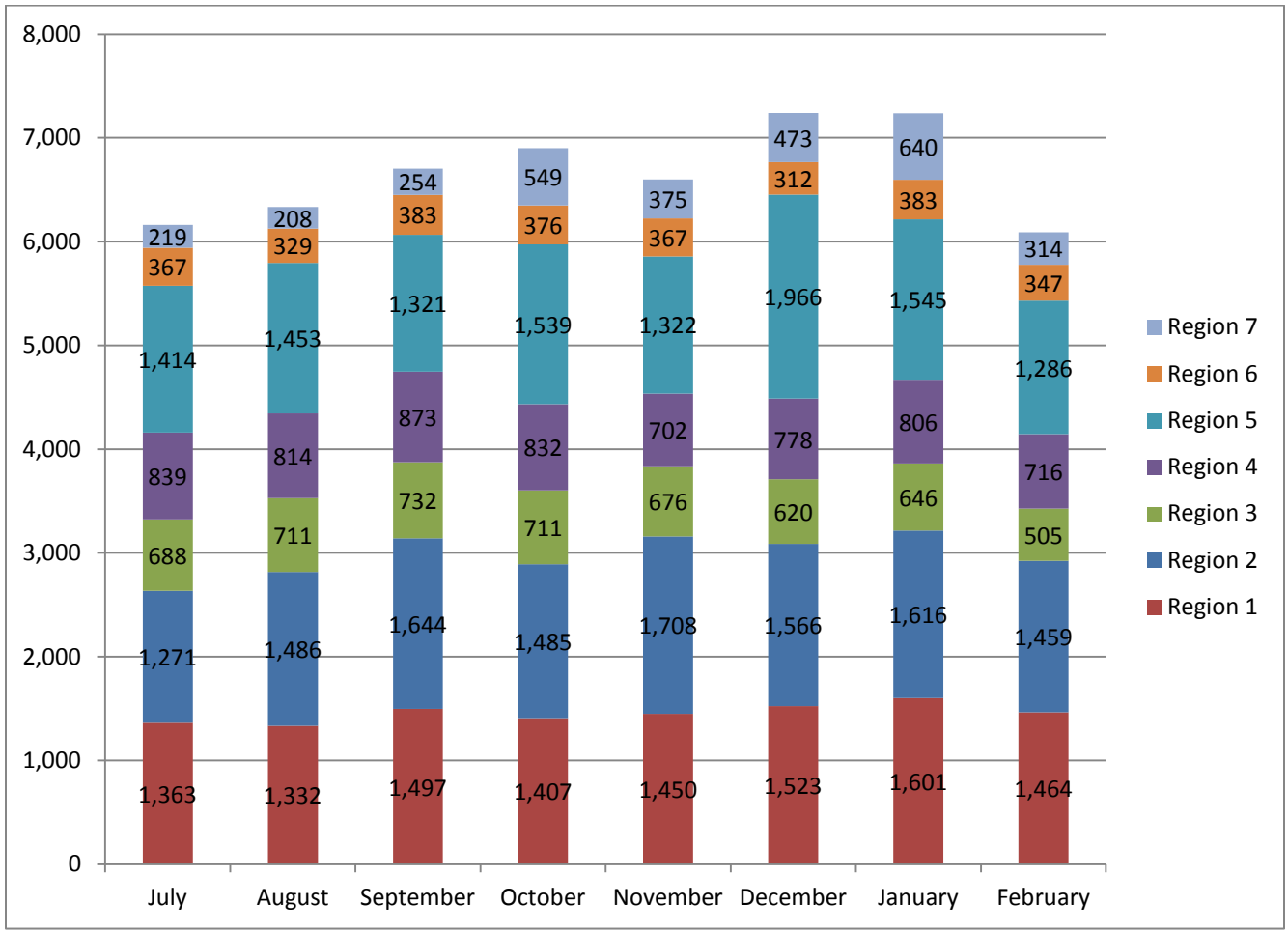


Table 2. Number of emergency evaluations (corresponds with graph 2a)

Region	July	August	September	October	November	December	January	February	Total
Region 1	1,363	1,332	1,497	1,407	1,450	1,523	1,601	**1,464**	**11,637**
Region 2	1,271	1,486	1,644	1,485	1,708	1,566	1,616	**1,459**	**12,235**
Region 3	688	711	732	711	676	620	646	**505**	**5,289**
Region 4	839	814	873	832	702	778	806	**716**	**6,360**
Region 5	1,414	1,453	1,321	1,539	1,322	1,966	1,545	**1,286**	**11,846**
Region 6	367	329	383	376	367	312	383	**347**	**2,864**
Region 7	219	208	254	549	375	473	640	**314**	**3,032**
Total	**6,161**	**6,333**	**6,704**	**6,899**	**6,600**	**7,238**	**7,237**	**6,091**	**53,263**

Graph 3a. TDOs issued by region

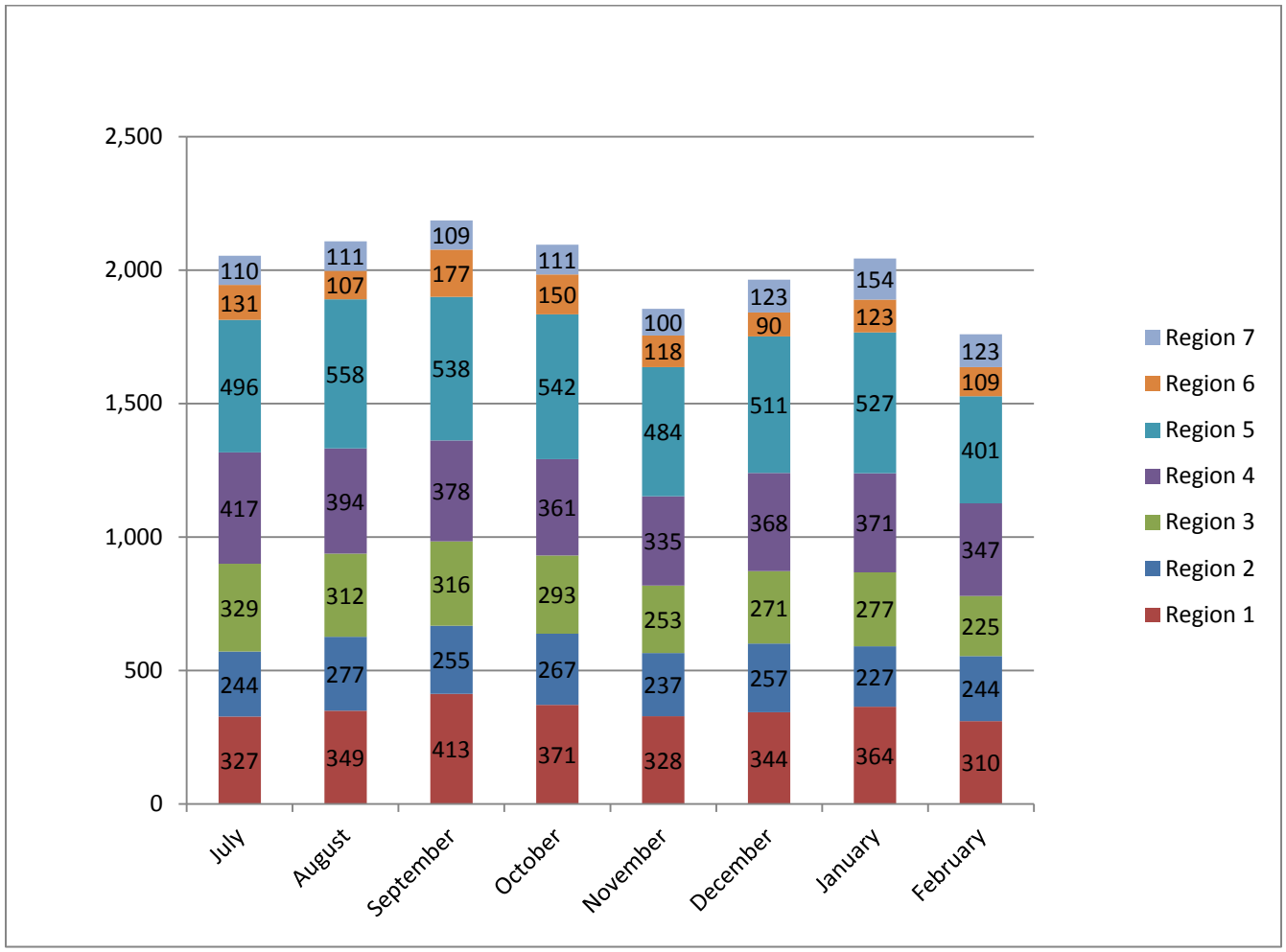


Table 3. Number of TDOs issued (corresponds with graph 3a)

Region	July	August	September	October	November	December	January	February	Total
Region 1	327	349	413	371	328	344	364	**310**	**2,806**
Region 2	244	277	255	267	237	257	227	**244**	**2,008**
Region 3	329	312	316	293	253	271	277	**225**	**2,276**
Region 4	417	394	378	361	335	368	371	**347**	**2,971**
Region 5	496	558	538	542	484	511	527	**401**	**4,057**
Region 6	131	107	177	150	118	90	123	**109**	**1,005**
Region 7	110	111	109	111	100	123	154	**123**	**941**
Total	**2,054**	**2,108**	**2,186**	**2,095**	**1,855**	**1,964**	**2,043**	**1,759**	**16,064**

Virginia Department of Behavioral Health & Developmental Services

Graph 4a. TDOs executed by region

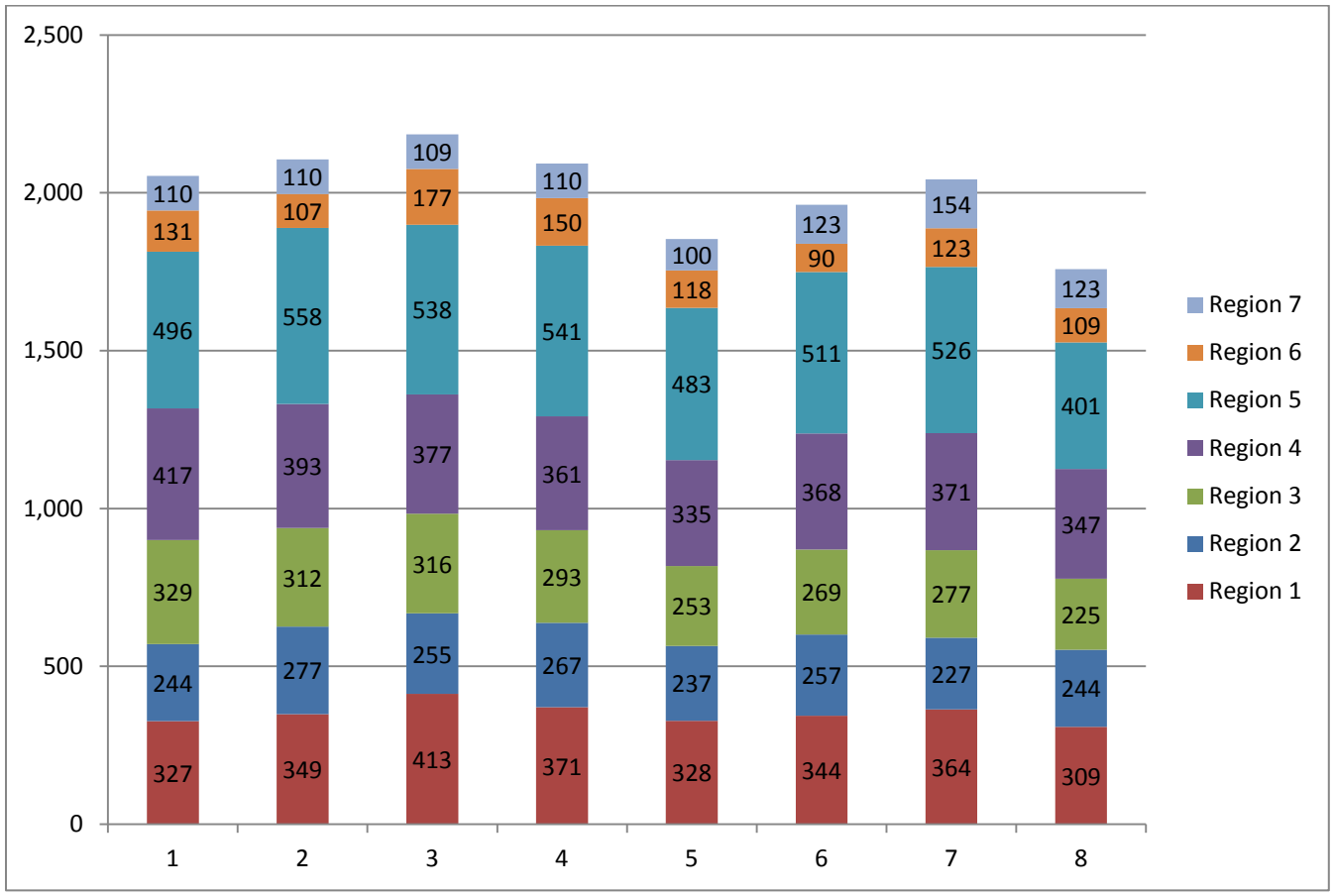


Table 4. Number of TDOs executed (corresponds with graph 4a)

Region	July	August	September	October	November	December	January	February	Total
Region 1	327	349	413	371	328	344	364	**309**	**2,805**
Region 2	244	277	255	267	237	257	227	**244**	**2,008**
Region 3	329	312	316	293	253	269	277	**225**	**2,274**
Region 4	417	393	377	361	335	368	371	**347**	**2,969**
Region 5	496	558	538	541	483	511	526	**401**	**4,054**
Region 6	131	107	177	150	118	90	123	**109**	**1,005**
Region 7	110	110	109	110	100	123	154	**123**	**939**
Total	**2,054**	**2,106**	**2,185**	**2,093**	**1,854**	**1,962**	**2,042**	**1,758**	**16,054**

Graph 5a. TDO admissions to a state hospital by region

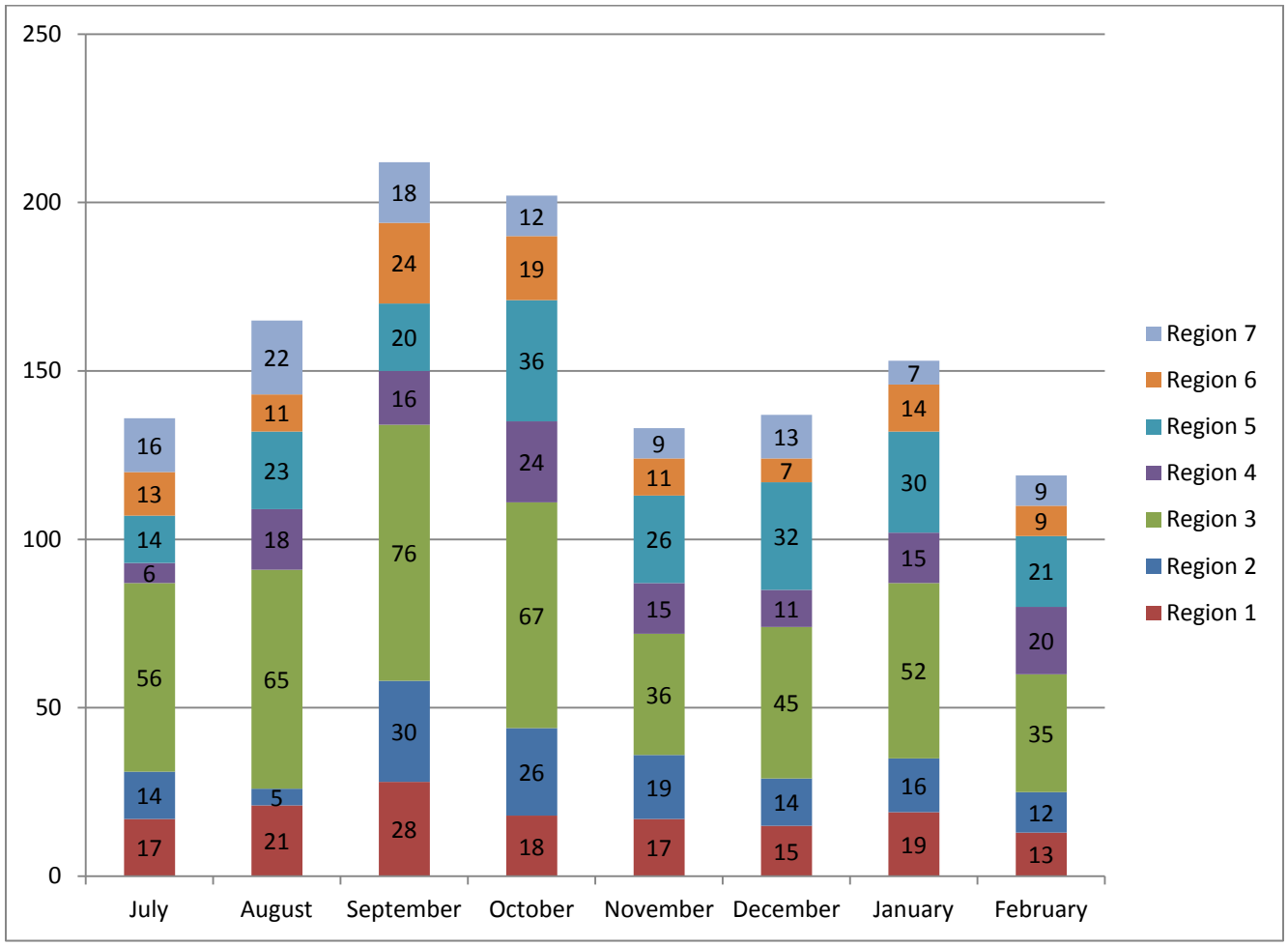


Table 5. TDO admissions to a state hospital (corresponds with graph 5a)

Region	July	August	September	October	November	December	January	February	Total
Region 1	17	21	28	18	17	15	19	**13**	**148**
Region 2	14	5	30	26	19	14	16	**12**	**136**
Region 3	56	65	76	67	36	45	52	**35**	**432**
Region 4	6	18	16	24	15	11	15	**20**	**125**
Region 5	14	23	20	36	26	32	30	**21**	**202**
Region 6	13	11	24	19	11	7	14	**9**	**108**
Region 7	16	22	18	12	9	13	7	**9**	**106**
Total	**136**	**165**	**212**	**202**	**133**	**137**	**153**	**119**	**1,257**

Virginia Department of Behavioral Health & Developmental Services

Graph 6a. State hospital admission delayed by region

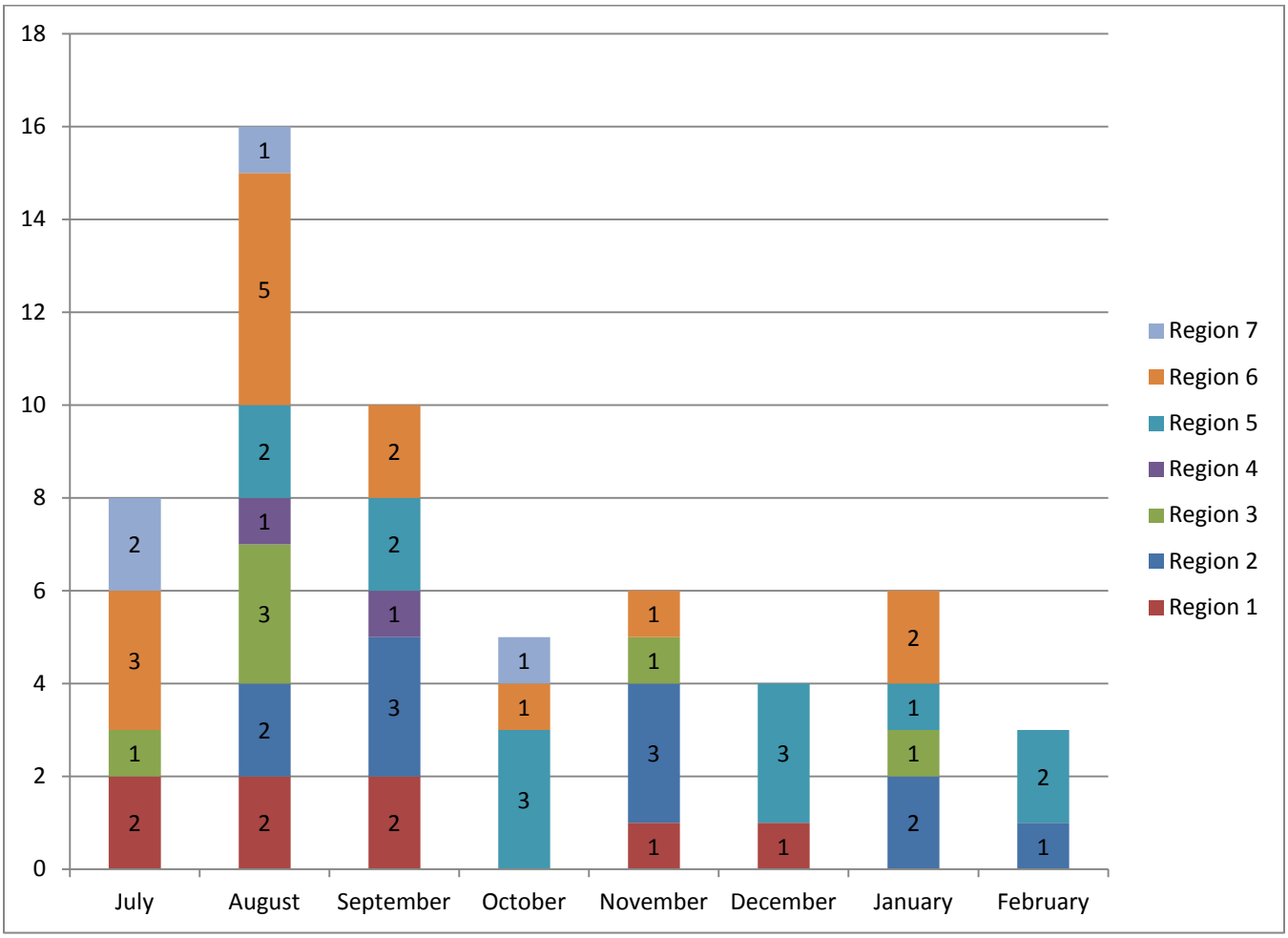


Table 6. State hospital admission delayed (corresponds with graph 6a)

Region	July	August	September	October	November	December	January	February	Total
Region 1	2	2	2	0	1	1	0	**0**	**8**
Region 2	0	2	3	0	3	0	2	**1**	**12**
Region 3	1	3	0	0	1	0	1	**0**	**6**
Region 4	0	1	1	0	0	0	0	**0**	**2**
Region 5	0	2	2	3	0	3	1	**2**	**13**
Region 6	3	5	2	1	1	0	2	**0**	**14**
Region 7	2	1	0	1	0	0	0	**0**	**4**
Total	**8**	**16**	10	**5**	**6**	**4**	**6**	**3**	**58**

Graph 7a. TDO executed after ECO expired by region

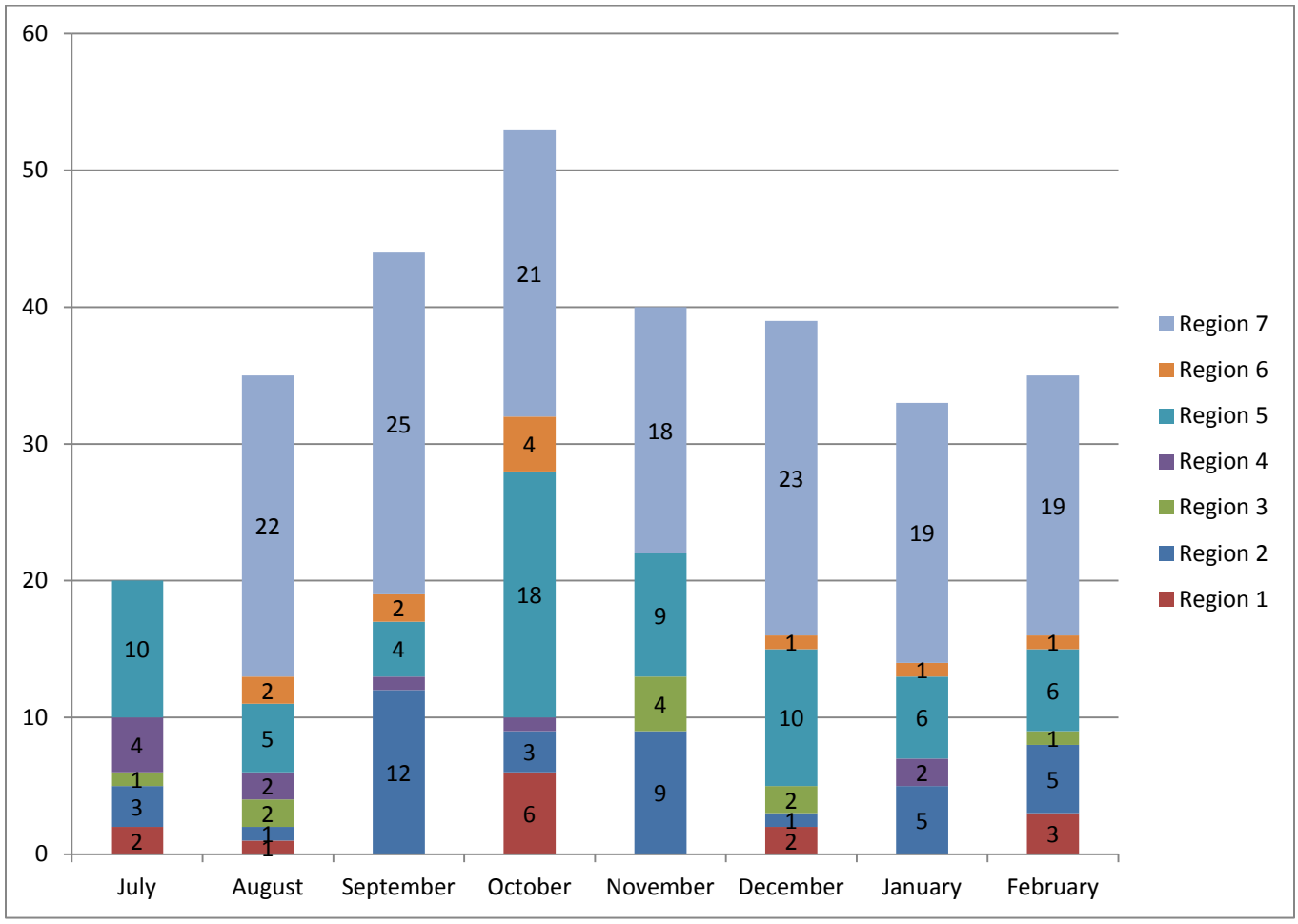


Table 7. TDO executed after ECO expired (corresponds with graph 7a)

Region	July	August	September	October	November	December	January	February	Total
Region 1	2	1	0	6	0	2	0	**3**	**14**
Region 2	3	1	12	3	9	1	5	**5**	**39**
Region 3	1	2	0	0	4	2	0	**1**	**10**
Region 4	4	2	1	1	0	0	2	**0**	**10**
Region 5	10	5	4	18	9	10	6	**6**	**68**
Region 6	0	2	2	4	0	1	1	**1**	**11**
Region 7	0	22	25	21	18	23	19	**19**	**147**
Total	**20**	**35**	44	**53**	**40**	**39**	**33**	**35**	**299**

Graph 8a. Transfers during temporary detention by region

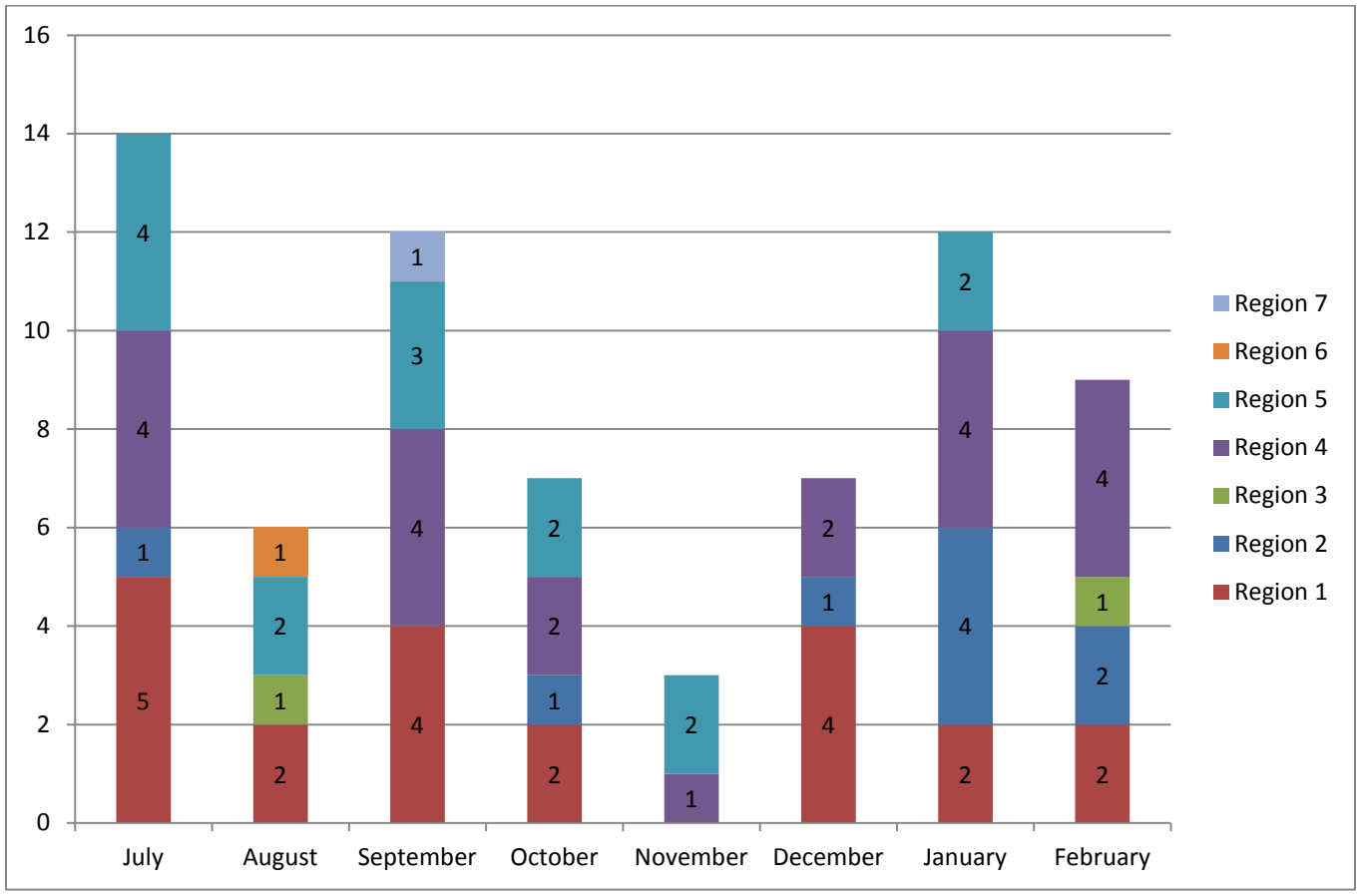


Table 8. Transfers during temporary detention (corresponds with graph 8a, pg 10)

Region	July	August	September	October	November	December	January	February	Total
Region 1	5	2	4	2	0	4	2	**2**	**21**
Region 2	1	0	0	1	0	1	4	**2**	**9**
Region 3	0	1	0	0	0	0	0	**1**	**2**
Region 4	4	0	4	2	1	2	4	**4**	**21**
Region 5	4	2	3	2	2	0	2	**0**	**15**
Region 6	0	1	0	0	0	0	0	**0**	**1**
Region 7	0	0	1	0	0	0	0	**0**	**1**
Total	**14**	**6**	**12**	**7**	**3**	**7**	**12**	**9**	**70**

Graph 9a. TDOs to state hospital without ECO by region

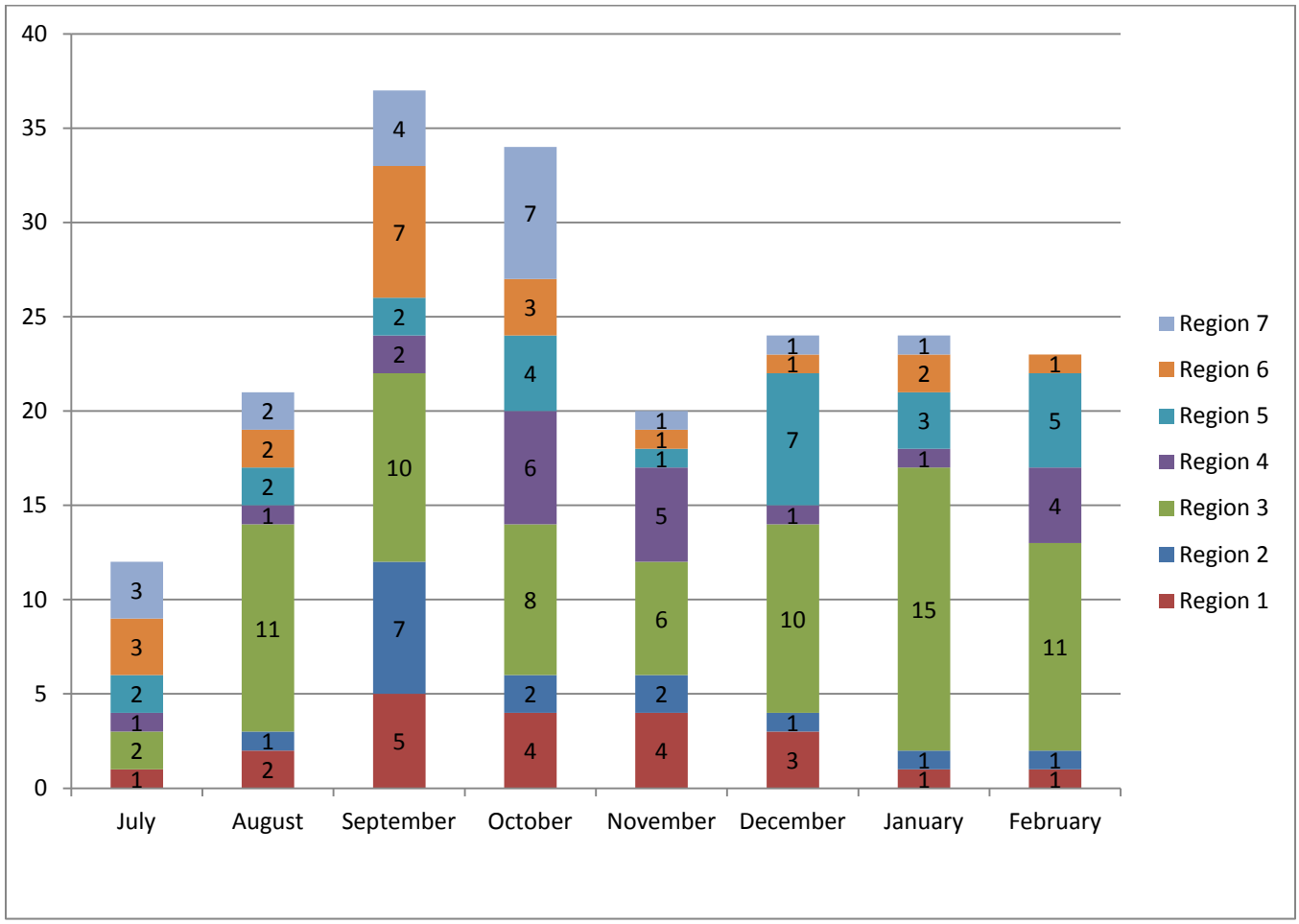


Table 9. State hospital TDOs without ECOs (corresponds with graph 9a)

Region	July	August	September	October	November	December	January	February	Total
Region 1	1	2	5	4	4	3	1	**1**	**21**
Region 2	0	1	7	2	2	1	1	**1**	**15**
Region 3	2	11	10	8	6	10	15	**11**	**73**
Region 4	1	1	2	6	5	1	1	**4**	**21**
Region 5	2	2	2	4	1	7	3	**5**	**26**
Region 6	3	2	7	3	1	1	2	**1**	**20**
Region 7	3	2	4	7	1	1	1	**0**	**19**
Total	**12**	**21**	**37**	**34**	**20**	**24**	**24**	**23**	**195**

APPENDIX D

DBHDS requires CSBs to report within 24-hours any event involving an individual who has been determined to require temporary detention for whom the TDO is not executed for any reason, whether or not an ECO was issued or in effect. These reports are sent to a DBHDS Quality Oversight team that includes the DBHDS Medical Director, the Assistant Commissioner for Behavioral Health, the Director of Mental Health Services, and the MH Crisis Specialist. Each report contains the CSB's description of the incident and the CSB's proposed actions to resolve the event and prevent such occurrences in the future. In each case, the DBHDS Quality Oversight team examines the report for completeness, and comprehensiveness, and responds immediately to the CSB Executive Director if any further information is needed. In addition, DBHDS specifies additional follow up actions that are deemed necessary, and requests appropriate follow up communication from the CSB, maintaining an open incident file until the incident has resolved and the follow up actions are completed.

There were four such events during the month of February 2015. The four reported cases are summarized below. DBHDS has followed up with the relevant CSB in each of these events to gather additional information and to give to the CSB specific clinical and quality feedback about how each case was handled, what behaviors or procedures may have contributed to the event, what clinical and administrative or process issues need to be addressed in developing solutions to the problems encountered, strategies to implement with partner entities, etc. These case-driven DBHDS interventions are still ongoing at the time of this report.

Of the four cases reported in February, three involved individuals who were initially evaluated on a voluntary basis (i.e., the individuals were not under an ECO), while the fourth was evaluated while under an ECO. Of these four cases, two individuals eloped from the evaluation site before the TDO was executed. One of these individuals was subsequently detained and the other individual has not been located. The third individual was evaluated as a voluntary patient while on a medical unit. While the evaluator was conducting a search for an appropriate facility for temporary detention, a doctor of the medical facility discharged the individual despite being aware of the intended TDO. The individual was subsequently detained. The fourth individual remained in law enforcement custody while technical issues with the fax machines were resolved in the local medical facility where the individual was located. The individual was subsequently detained. These case summaries follow.

1. This individual was seen as a voluntary, walk-in for a crisis assessment and was later determined to meet TDO criteria as he was unwilling to seek inpatient treatment. When the individual became aware that a TDO would be pursued he became highly agitated and left the ED. The CSB evaluator followed the individual to obtain the make, model, and license plate number of his vehicle. Law enforcement was contacted and provided with descriptors of the individual, the vehicle information as well as all known addresses for the individual. Law enforcement notified the CSB evaluator that the current address is an unoccupied dwelling. The law enforcement agency placed the individual on the Nationwide Database for Missing and Suicidal Persons. The CSB continued its efforts to contact

the individual by calling all phone numbers on file for the individual as well as contacting the individual's emergency contact for information. With consultation from the DBHDS Quality Oversight Team, the CSB met with the hospital emergency department and senior administrators to develop and implement measures to better safeguard individuals in these circumstances. The CSB has been in contact with the individual's brother in an attempt to locate the individual. The individual does not have a known residence according to the brother. His brother has the CSB contact information when he is able to locate the individual. The local law enforcement agency has kept the individual's name on the national database.

2. This individual was evaluated while under an ECO and found to meet TDO criteria. The CSB evaluator, following regional admission protocol, initiated phone contact with the state facility seeking an acceptance of the individual due to the ECO time period getting close to expiring. The evaluator attempted to fax the necessary forms and lab work to the state facility but was unable to find a working fax machine in the medical facility by the time the ECO expired [Note: the problems were from network outages]. The law enforcement officer having custody remained with the individual following the ECO expiration until the TDO was executed by another officer. There was no lapse in custody. The DBHDS Quality Oversight Team reviewed the incident and suggested the CSB work with community partners to provide working equipment for their use while in the hospital setting. DBHDS supported the CSB to develop an alternate plan for accessing the state beds when there are technical difficulties such as allowing for a verbal exchange of information. The CSB Executive Director had contact with the state facility director to work on this revision to the regional admission protocols.

3. The individual was evaluated on a medical unit while receiving medical treatment for a self-inflicted injury. The individual was found to meet TDO criteria and a bed search began. The evaluator contacted 16 facilities and was unable to locate a willing detention facility except for two that agreed to accept the individual once medical care had been provided with no remission for 24 hours. The individual was agreeable to remaining on the medical unit and completing medical treatment. Upon notification of the completion of necessary medical care, the CSB continued to pursue a willing facility. A physician at the medical hospital wanted to discharge the individual to his home, with family, despite reports from the nurses and other medical facility staff that the family was increasing the individual's agitation on the medical unit to the degree that security was on standby and physical restraint was used to maintain safety. The CSB contacted the physician to ask him to delay the discharge while they continued to secure a willing facility. The physician refused, signed the discharge order, and the individual was released from the medical facility. The CSB located a willing facility and obtained a TDO which allowed the individual to be examined in an emergency department prior to transport to the temporary detention facility. Approximately one hour and thirty minutes elapsed between the TDO being issued and executed despite the CSB's requesting that law enforcement execute the order in more promptly due to the risk of the individual harming himself at home. The individual was subsequently detained in an appropriate facility. The DBHDS Quality Oversight Team reviewed the incident and asked the CSB work with community partners to discuss the process and

outcome of this incident. Representatives of the Quality Oversight Team also attended a local meeting with the CSB emergency services, law enforcement and hospital partners to support a more collaborative process in the temporary detention process.

4. This individual presented to the local emergency department (ED) voluntarily seeking help but was determined by hospital staff to be unwilling to accept voluntary hospitalization and at risk of causing self harm. The individual was evaluated by the CSB in the ED and determined to meet the criteria for a TDO. The evaluator was typing the preadmission screening report for the accepting hospital when the individual threatened to leave the ED. The individual was informed that he must remain in the ED or the police would be called to take him into custody pending temporary detention. The evaluator notified the ED staff, including their security officers, of the individual's threats to leave. The evaluator also notified the local law enforcement agency for assistance and contacted the magistrate. Upon the arrival of the law enforcement officer at the ED, the evaluator briefed him on the situation including the actions being taken to petition for a TDO from the magistrate. The officer refused to take custody of the individual on a paperless ECO because the individual had not made any statements in front of this officer. The evaluator was notified by the ED staff that the individual and the officer had both left the ED. The evaluator petitioned the magistrate for a paper ECO but the evaluator was requested to petition for a TDO instead. The magistrate issued the TDO and the TDO was executed within 90 minutes of the individual leaving the ED. The DBHDS Quality Oversight Team reviewed the incident and suggested the CSB work with law enforcement and the ED to discuss the process and outcome of this incident. The CSB had their CIT Liaison contact and meet with the local law enforcement agency about the need for officers to accept information from credible witnesses when the officer is asked to take an individual into custody on a paperless ECO. The CSB had established ongoing meetings with administrators and directors of the local medical facility regarding their collective responsibility to keep individuals safe when in the ED or on a medical floor.

All of these incidents were reported to DBHDS in accordance with the established protocol within 24 hours. As described above, in response to these cases, DBHDS and CSBs initiated targeted interventions with the individuals involved, and remedial efforts with service delivery partners to mitigate risks and improve processes and care coordination. DBHDS is monitoring these cases and actively working with regions and CSBs to identify and address factors contributing to the problems described in this TDO exceptions report.